NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 8, 2003

RE: MDR Tracking #: M2-03-0763-01-SS
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an orthopedic surgeon physician reviewer who is board certified in orthopedic surgery. The orthopedic surgeon physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The claimant is a thirty-six year old female who reportedly sustained a work compensable injury to the lower back on ___. The claimant is treated for diagnosis of "mechanical low back pain and lower extremity pain". Neurologic exam is normal. An MRI report dated August 5, 2002 indicates a degenerative disc at L5-S1. Mild central bulging of the disc is noted at L5-S1. A lumbar myelogram and CT scan report of September 25, 2002 was unremarkable.

Requested Service(s)

Anterior lumbar interbody fusion followed by posterior minimally invasive percutaneous pedicle screw fixation at L5-S1.

Decision

Documentation does not support that the requested intervention is medically necessary.

Rationale/Basis for Decision

There are no objective studies localizing pain generator to the L5-S1 level. There is no EMG nerve conduction study documenting a presence of radiculopathy specifically localized to the L5-S1 level. There is no report of discography localizing a pain generator to the L5-S1 level.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (pre-authorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).
Sincerely,

cc:

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requester and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 8th day of April 2003.